Precision Vascular
VEINS + ARTERIES

Name_____

General Patient Questions **Age**_____

Reason for Visit_____

Gynecology Medical History		
Number of pregnancies		
Number of births		
Number of miscarriages		
Number of abortions		
Number of children		
Number of days per period		
Number of pads/day		
Number of tampons/day		
Date of last period		
Date of last pap smear		
Trying to get pregnant	Yes	No
Plan to get pregnant if future	Yes	No
Heavy menstrual periods	Yes	No
Passing clots	Yes	No
Spotting between periods	Yes	No
Pain with periods	Yes	No
Pain between periods	Yes	No
Pelvic pressure	Yes	No
Pain during intercourse	Yes	No

Pain after intercourse	Yes	No
Back pain	Yes	No
Frequent urination	Yes	No
Constipation	Yes	No
Symptoms have lasted months	Yes	No
Symptoms have lasted years	Yes	No
Symptoms getting worse	Yes	No
Anemia	Yes	No
Taking iron	Yes	No
Blood transfusion	Yes	No
Prior hormone treatment	Yes	No
Current hormone treatment	Yes	No
Hot flashes	Yes	No
In menopause	Yes	No
Prior pelvic surgery	Yes	No
Prior pelvic ultrasound	Yes	No
Have had other pelvic imaging	Yes	No
Varicose veins	Yes	No
Veins on abdomen	Yes	No

Prior Treatments	Year

Doctor Notes

Activity Level	
Fully active	0
Restricted in strenuous activity, able to do light work	1
Can walk, provide all self care, moves more than 50% while awake	2
Limited self care, confined to bed more than 50% while awake	3
Disabled, no self care, completely confined to bed or chair	4

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General History						Comments
Arthritis	Yes	No	Hepatitis A	Yes	No	
Asthma	Yes	No	Hepatitis B or C	Yes	No	
Bleeding tendency	Yes	No	High blood pressure	Yes	No	
Cancer	Yes	No	High thyroid	Yes	No	
Breast	Yes	No	HIV / AIDS	Yes	No	
Colon	Yes	No	Keloid formation	Yes	No	
Lung	Yes	No	Kidney disease	Yes	No	
COPD / Emphysema	Yes	No	Liver disease	Yes	No	
Deep vein thrombosis	Yes	No	Low thyroid	Yes	No	
Diabetes	Yes	No	Lupus	Yes	No	
Dialysis	Yes	No	Pneumonia	Yes	No	
GERD / Ulcers	Yes	No	Seizure	Yes	No	
Heart attack	Yes	No	Stroke	Yes	No	
Heart failure	Yes	No				

Social History			Type / Frequency / How long
Alcohol use	Yes	No	
Tobacco use	Yes	No	
Recreational drug use	Yes	No	

Previous Hospitalizations	Year

Previous Surgery	Year

Active Medical Problems	Onset

Allergies	Symptoms

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Family History	Alive		Medical Problems
Mother	Yes	No	
Father	Yes	No	
Brother	Yes	No	
Sister	Yes	No	
	Yes	No	
	Yes	No	

Medications	Reason

Review of Systems	**Circle all that apply**		
Constitutional Symptoms	**Genitourinary**	**Neurological**	**Eyes**
Good general health	Painful urination	Frequent or recurring headaches	Wear glasses
Recent weight loss	Blood in urine	Light headed or dizzy	Wear contact lenses
Recent weight gain	Incontinence or dribbling	Numbness or tingling	Blurred or double vision
Fever	Kidney stones	Tremors	Cataracts
Chills	**Musculoskeletal**	Paralysis	**Ears / Nose / Mouth / Throat**
Fatigue	Back pain	**Allergic/Immunologic**	Hearing loss
Cardiovascular	Pain radiating down legs	Prior adverse reaction to:	Ringing in the ears
Palpitations	Hip pain	Penicillin or other antibiotics	Earaches
Chest pain or angina	Knee pain	Morphine or other narcotics	Sinus problem
Irregular heart beat	Shoulder pain	Lidocaine or other anesthetics	Nose bleeds
Pacemaker	Joint stiffness	Aspirin or other pain remedies	Mouth sores
Swelling of feet or ankles	Joint swelling	Iodine	Sore throat
Sores on feet or ankles	Muscle weakness	Betadine	Swollen glands in neck
Leg cramps walking	Muscle cramps	**Skin / Breast**	**Psychiatric**
Gastrointestinal	**Respiratory**	Rash	Memory loss
Loss of appetite	Chronic cough	Breast pain	Nervousness
Nausea or vomiting	Shortness of breath	Breast discharge	Depression
Diarrhea	Wheezing	Breast lump	Confusion
Constipation	**Endocrine**	**Hematologic/Lymphatic**	Insomnia
Blood in bowel movements	Hormone problem	Slow to heal after cuts	
Abdominal pain	Excessive thirst	Easy bruising	
	Heat or cold intolerance		

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Postural Orthostatic Hypotension Syndrome (P.O.T.S.) Questionnaire:

1. Rate your level of fatigue on a scale of 1-10 (1= not very fatigued, 10= extremely fatigued). ___

2. If appropriate, to what degree do your abdominal symptoms (pain, constipation, diarrhea, etc.) affect your life? (1= not very much, 10= greatly). _____

3. How often have you felt faint upon standing or with prolonged standing in the past month? (1=not at all 2=occasionally 3=frequently 4=always) ___

4. If appropriate, to what degree does your anxiety and/or depression affect your life? (1= not very much, 10=greatly) ____

5. If appropriate, to what degree does your decreased concentration (brain fog) affect your life? (1= not very much, 10= greatly) ____

6. Please rate your current quality of life. (1= wonderful quality of life, 10= poor quality of life) ___

7. Please list the complaints which most greatly affect your life and/or cause you the greatest discomfort if not already discussed above, and assign each a number from 1-10 based on severity (1= not too bad, 10= very bad) Attach additional sheet if necessary

_____ _____

_____ _____

_____ _____

_____ _____